

**CHAPTER 514**  
**NURSING FACILITY SERVICES**

**APPENDIX 514A**  
**PRE-ADMISSION SCREENING (PAS) 2000**  
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# WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

## PRE-ADMISSION SCREENING

**Reason for Screening:**

Check Only One

- A. Nursing Home Only: Initial    Transfer  
 B. Nursing Home waiting Waiver: yes  
 C. A/D Waiver Only: Initial    Re-Evaluation  
 D. Personal Care: Initial    Re-Evaluation

**Facility/Agency/Person making referral:**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

FAX: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### 1. DEMOGRAPHIC INFORMATION

1. Individuals Full Name		2. Sex		3. Medicaid Number		4. Medicare Number	
		F    M					
5. Address (Including Street/Box, City, State & Zip)						6. Private Insurance	
7. County	8. Social Security Number		9. Birth date (M/D/Y)		10. Age	11. Phone Number	
12. Spouses Name			13. Address (If different from above)				
14. Current living arrangements, including formal and informal support (i.e., family, friends, other services) _____ _____							
15. Name and Address of Provider, if applicable: _____ _____							
16. Medicaid Waiver Recipient   a. Yes   b. No   c. Aged/Disabled   d. MR/DD							
17. Has the option of Medicaid Waiver been explained to the applicant? a. Yes   b. No							
18. For the purpose of determining my need for appropriate services, I authorize the release of any medical information by the physician to the Department of Health and Human Resources or its representative. _____ / _____ / _____ SIGNATURE - Applicant or Person acting for Applicant      Relationship      Date							
19. Check if Applicant has any of the following: a. Guardian                                  d. Power of Attorney                                  g. Other _____ b. Committee                                  e. Durable Power of Attorney c. Medical Power of Attorney                  f. Living Will  Name & Address of the Representative _____ _____ Phone: (____) _____ - _____							

## II. MEDICAL ASSESSMENT

Date \_\_\_\_\_

Name \_\_\_\_\_

**20. Health Assessment - Include infectious diseases, nutritional needs, prior treatments, degenerative conditions, recent hospitalization(s), and/or surgery(ies) with dates - Date of most recent office visit. (Attach most recent Hospital Discharge Summary and Physical, if available)**

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### 21. Normal Vital Signs for the individual:

a. Height	b. Weight	c. Blood Pressure	d. Temperature	e. Pulse	f. Respiratory Rate
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### 22. Check if Abnormal:

a. Eyes	g. Breasts	m. Extremities	s. Musculo-Skeletal
b. Ears	h. Lungs	n. Abdomen	t. Skin
c. Nose	i. Heart	o. Hernia(s)	u. Nervous System
d. Throat	j. Arteries	p. Genitalia-male	v. Allergies (Specify) _____
e. Mouth	k. Veins	q. Gynecological	
f. Neck	l. Lymph System	r. Ano-Rectal	

Describe abnormalities and treatment:

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### 23. Medical Conditions/Symptoms: [Please Grade as : (1) - Mild, (2) - Moderate, (3) - Severe]

a. Angina-rest _____	e. Paralysis _____	i. Diabetes _____
b. Angina-exertion _____	f. Dysphagia _____	j. Contracture(s) _____
c. Dyspnea _____	g. Aphasia _____	k. Mental Disorder(s) _____
d. Significant Arthritis _____	h. Pain _____	l. Other (Specify) _____

### 24. Decubitus    a. Yes    b. No    If yes, check the following:

A. Stage \_\_\_\_\_ B. Size \_\_\_\_\_ C. Treatment \_\_\_\_\_

Location:    a. Left Leg    c. Right Leg    e. Left Hip    g. Right Hip  
                  b. Left Arm    d. Right Arm    f. Left Buttock    h. Right Buttock

Other \_\_\_\_\_ Developed at:    a. 9 Home    b. 9 Hospital    c. 9 Facility

### 25. In the event of an emergency, the individual can vacate the building: (check only one)

a. Independently    b. With Supervision    c. Mentally Unable    d. Physically Unable

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

**26. Indicate individual's functional ability in the home for each item with the level number 1, 2, 3, 4, or 5. Nursing care plan must reflect functional abilities of the client in the home.**

Item	Level 1	Level 2	Level 3	Level 4
a. __ Eating (not a meal Prep)	Self/Prompting	Physical Assistance	Total Feed	Tube Fed
b. __ Bathing	Self/Prompting	Physical Assistance	Total Care	
c. __ Dressing	Self/Prompting	Physical Assistance	Total Care	
d. __ Grooming	Self/Prompting	Physical Assistance	Total Care	
e. __ Cont./Bladder	Continent	Occas. Incontinent*	Incontinent	Catheter
f. __ Cont./Bowel	Continent	Occas. Incontinent*	Incontinent	Colostomy
g. __ Orientation		*less than 3 per wk.		
h. __ Transferring	Oriented	Intermittent Disoriented	Totally Disoriented	Comatose (Level 5)
i. __ Walking	Independent	Supervised/Assistive	One Person Assistance	Two Person Assist.
j. __ Wheeling		Devise	One Person Assistance	Two Person Assist.
k. __ Vision	Independent		Situational Assistance	Total Assistance
l. __ Hearing	No Wheelchair	Supervised/Assistive	(Doors, etc.)	
m. __ Communication	Not Impaired	Devise	Impaired/Not Correctable	Blind
	Not Impaired	Wheels Independently	Impaired/Not Correctable	Deaf
	Not Impaired	Impaired /Correctable	Understandable with Aids	Inappropriate/None
		Impaired/Correctable		
		Impaired/Understandable		

**27. Professional and technical care needs (check all that apply).**

- |                         |                 |                      |
|-------------------------|-----------------|----------------------|
| a. Physical Therapy     | f. Ostomy       | k. Parenteral Fluids |
| b. Speech Therapy       | g. Suctioning   | l. Sterile Dressings |
| c. Occupational Therapy | h. Tracheostomy | m. Irrigations       |
| d. Inhalation Therapy   | i. Ventilator   | n. Special Skin Care |
| e. Continuous Oxygen    | j. Dialysis     | o. Other _____       |

**28. Individual is capable of administering his/her own medications (check only one).**

a. Yes      b. With Prompting/Supervision      c. No      Comment: \_\_\_\_\_

29. Current Medications	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

### III. MI/MR ASSESSMENT

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

**30. Current Diagnoses (Check all that apply)**

- |  |  |
|--|--|
| a. None  | g. Schizophrenic Disorder                    |
| b. Mental Retardation                                | h. Paranoid Disorder                         |
| c. Autism  | i. Major Affective Disorder                  |
| d. Seizure Disorder (Age at onset: _____)            | j. Schizoaffective Disorder                  |
| e. Cerebral Palsy                                    | k. Affective Bipolar Disorder                |
| f. Other Developmental Disabilities (Specify: _____) | l. Tardive Dyskinesia                        |
|  | m. Major Depression                          |
|  | n. Other related conditions (Specify: _____) |

Date of last PASARR Level II Evaluation \_\_\_\_\_

**31. Has an individual ever received services from an agency serving persons with mental retardation/developmental disability and/or mental illness?**      ☐ Yes      ☐ No      If yes, specify agency \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Admission Date \_\_\_\_\_

Discharge Date \_\_\_\_\_

**32. Has the individual received any of the following medications on a regular basis within the last two years?**  
☐ Yes    ☐ No

**33. Was this medication used to treat a neurological disorder?**      ☐ Yes    ☐ No

- |   |                                    |   |                                    |   |                                   |
|---|------------------------------------|---|------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Chlorpromazine | <input type="checkbox"/> Thorazine | <input type="checkbox"/> Perphenazine     | <input type="checkbox"/> Trilafon  | <input type="checkbox"/> Haloperidol      | <input type="checkbox"/> Haldol   |
| <input type="checkbox"/> Promazine      | <input type="checkbox"/> Sparine   | <input type="checkbox"/> Fluphenazine     | <input type="checkbox"/> Prolixin  | <input type="checkbox"/> Molindone        | <input type="checkbox"/> Moban    |
| <input type="checkbox"/> Trifupromazine | <input type="checkbox"/> Vesprin   | <input type="checkbox"/> Fluphenazine HCl | <input type="checkbox"/> Permitil  | <input type="checkbox"/> Loxapine         | <input type="checkbox"/> Loxitane |
| <input type="checkbox"/> Thiodiazine    | <input type="checkbox"/> Mellaril  | <input type="checkbox"/> Trifluphenazine  | <input type="checkbox"/> Stelazine | <input type="checkbox"/> Clozapine        | <input type="checkbox"/> Clozaril |
| <input type="checkbox"/> Mesoridazine   | <input type="checkbox"/> Serentil  | <input type="checkbox"/> Chlorprothixene  | <input type="checkbox"/> Taractan  | <input type="checkbox"/> Prochlorperazine |                                   |
| <input type="checkbox"/> Actiphenazine  | <input type="checkbox"/> Tindal    | <input type="checkbox"/> Thiothixene      | <input type="checkbox"/> Navane    | <input type="checkbox"/> Compazine        |                                   |

Medication	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

**34. Clinical and Psychosocial Data - Please check any of the following behaviors which the individual has exhibited in the past two years.**

- |   |   |
|---|---|
| a. Substance Abuse (Identify _____)       | k. Seriously Impaired Judgment                              |
| b. Combative                              | l. Suicidal Thoughts, Ideations/Gestures                    |
| c. Withdrawn/Depressed                    | m. Cannot Communicate Basic Needs                           |
| d. Hallucinations                         | n. Talks About His/Her Worthlessness                        |
| e. Delusional                             | o. Unable to Understand Simple Commands                     |
| f. Disoriented                            | p. Physically Dangerous to Self and Others, if Unsupervised |
| g. Bizarre Behavior                       | q. Verbally Abusive   |
| h. Bangs Head                             | r. Demonstrates Severe Challenging Behaviors                |
| i. Sets Fires                             | s. Specialized Training Needs                               |
| j. Displays Inappropriate Social Behavior | t. Sexually Aggressive                                      |

Does the individual have Alzheimer's, multi-infarct, senile dementia, or related condition?    ☐ Yes    ☐ No

Other (Specify) \_\_\_\_\_

#### IV. PHYSICIAN RECOMMENDATION

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

<b>35. Prognosis - Check one only:</b> a__ Stable b__ Improving c__ Deteriorating d__ Terminal  Other _____	
<b>36. Rehabilitative Potential (Check one only)</b> a__ Good b__ Limited c__ Poor	
<b>37. Diagnosis:</b>  a. Primary _____ b. Secondary _____ c. Other medical conditions requiring services _____	
<b>38. Physician Recommendations</b>	
<b>A. FOR NURSING FACILITY PLACEMENT ONLY</b> On the basis of present medical findings, the individual may eventually be able to return home or be discharged.  a__ Yes b__ No  If yes, check one of the following:  a. Less than 3 months b. 3-6 months c. Over 6 months d. Terminal illness	<b>B. I recommend that the services and care to meet these needs can be provided at the level of care indicated.</b>  a. Nursing Home b. Nursing Home waiting A/D Waiver c. A/D Waiver d. Personal Care
<b>39. To the best of my knowledge, the patient's medical and related needs are essentially as indicated above (Must be signed by M.D. or D.O.)</b>	
_____ <b>Physicians Signature</b> <b>MD/DO</b>  _____ <b>Date This Assessment Completed:</b>	<b>TYPE OR PRINT Physicians name/address below:</b>  _____ _____ _____ _____

**DISCLAIMER:** Approval of this form does not guarantee eligibility for payment under the State Medicaid Plan.

**NOTE:** Information gathered from this form may be utilized for statistical/data collection.

**V. ELIGIBILITY DETERMINATION**

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

**DEPARTMENT USE ONLY****LEVEL I (Medical Screen)**

Medical and other professional personnel of the Medicaid Agency or its designees **MUST** evaluate each individuals need for admission by reviewing and assessing the evaluations required by regulation.

**Exemptions from requirements for Level II Assessment****40. Does the individual have or require:**

a. Diagnosis of dementia (Alzheimer's or related disorder)?	Yes	No
b. Thirty days of respite care?	Yes	No
c. Serious Medical Condition?	Yes	No

**41. Medical Eligibility Determination:**

a. Nursing Facility Services/Aged/Disabled Waiver	b. Personal Care Services
c. No Services Needed	d. Optional Services

**42. PASARR Determination:**

a. Level II required	b. Level II not required
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Nurse Reviewers Signature - Title \_\_\_\_\_

Date \_\_\_\_\_

Control Number \_\_\_\_\_

Printed Name \_\_\_\_\_

WAIVER ONLY: Level of Care: \_\_\_\_\_ Number of Hours: \_\_\_\_\_

**DEPARTMENTAL USE ONLY**  
**LEVEL II (MI/MR Screen)**  
(Completed by PASARR Provider)

**43. DETERMINATION:**

- a. Nursing facility services needed - Specialized services not needed.
- b. Nursing facility services needed - Specialized services needed.
- c. Alzheimer's or related disorder identified.
- d. Thirty day Respite care needed.
- e. Terminal illness identified.
- f. Serious illness identified.
- g. Nursing facility services not needed.

**44. RECOMMENDED PLACEMENT:**

- a. Nursing Facility Services/Aged/Disabled Wavier
- b. Psychiatric Hospital (21 years or under)
- c. ICF/MR or I/DD Waiver
- d. Other-Identify: \_\_\_\_\_

\_\_\_\_\_  
**PASARR Reviewers Signature**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Agency Name**

\_\_\_\_\_  
**Date**

A COPY OF THIS FORM MUST BE IN THE INDIVIDUAL'S MEDICAL RECORDS